Comparison of H.R. 2563 and Pending Medicaid Patient Protections

1. Emergency Access

In a speech to the American College of Cardiology in March, President Bush declared, "We must guarantee ***all patients***...the right to get emergency treatment at the nearest emergency room."[1] Consistent with this view, H.R. 2563 includes provisions to protect patients from managed care abuses in the event of a medical emergency.

Specifically, the bill prohibits plans from requiring patients to obtain pre-approval before seeking emergency care.[2] Plans also must pay for emergency care, as long as the patient suffers from a:

> "medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in a condition described in clause (i), (ii), or (iii) of section 1867(e)(1)(A) of the Social Security Act."[3]

The Social Security Act then defines these conditions as:

> "(A) Serious jeopardy to the health of the individual or, in the case of a pregnant woman, the health of the woman or her unborn child;
> (B) Serious impairment to bodily functions; or
> (C) Serious dysfunction of any bodily organ or part."[4]

Identical protections are part of the pending Medicaid rules. Health plans would be required to tell enrollees that "prior authorization is not required for emergency services."[5] Again, plans cannot refuse to pay for emergency care when a patient suffers from a:

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[1]Remarks by the President to the American College of Cardiology Annual Convention. March 21, 2001. (http://www.whitehouse.gov/news/releases/2001/03/20010321-2.html)

[2]H.R. 2563, Section 113(a)(1)(A)

[3]H.R. 2563, Section 113(a)(2)(A)

[4]42 USC 1396u-2(b)(2)(C)(i)-(iii).

[5]42 CFR 438.114(b)(2)

"medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in--

(A) Serious jeopardy to the health of the individual or, in the case of a pregnant woman, the health of the woman or her unborn child;
(B) Serious impairment to bodily functions; or
(C) Serious dysfunction of any bodily organ or part."[6]

2. Specialty Care

President Bush recently said, "We must guarantee ***all patients***...the right to see a specialist when they need one -- say, just for an example, the right to see a cardiologist for a heart problem."[7]

H.R. 2563 provides four key protections for individuals needing specialty care. First, the bill mandates that "participants, beneficiaries and enrollees receive timely access to specialists...when such specialty care is a covered benefit under the plan or coverage."[8] Second, managed care plans must provide for specialty care outside of the network when needed.[9] Third, patients are entitled to "standing referrals" when appropriate, so that they do not have to repeatedly get permission from a primary care physician to see a specialist.[10] Fourth, when conditions are "life-threatening, degenerative, potentially disabling or congenital" and require "specialized medical care over a prolonged period of time," patients have the right to have their care for that condition directed by a specialist.[11]

The pending Medicaid rules parallel the first three of the four provisions in H.R. 2563. Plans must ensure that "all covered services are available and accessible to enrollees,"[12] provide

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[6]42 CFR 422.113

[7]Remarks by the President to the American College of Cardiology Annual Convention. March 21, 2001. http://www.whitehouse.gov/news/releases/2001/03/20010321-2.html

[8]H.R. 2563, Section 114(a)(1)

[9]H.R. 2563, Section 114(a)(3)(A)

[10]H.R. 2563, Section 114(b)(1)(A)

[11]H.R. 2563, Section 114(b)(2)

[12]42 CFR 438.206(a)

essential out-of-network services,[13] and allow "a standing referral" for all patients with special health care needs.[14] The Medicaid rules are more modest than H.R. 2563, however, in that they do not grant a right for chronically ill patients to have their care directed by specialists.

3. Appeals Process

In President Bush's words, "If medical care is denied, patients should have the right to a fair and immediate review."[15] H.R. 2563 gives enrollees the right to two types of review of any coverage or benefit decisions: (1) review inside the managed care plan; and (2) review external to the plan by unbiased experts. For the internal review, plans must make a determination within 14 days (or 72 hours in the case of an emergency) in accordance with the medical exigencies of the case.[16] The decision must be made by a health professional not involved in the original denial of care,[17] and patients must be informed of their right to appeal the decision of the internal reviewer.[18]

The Medicaid rules also provide for an internal review of benefit or coverage decisions. The rules parallel those in H.R. 2563. Plans must make a determination within 30 days (or 72 hours in case of emergency).[19] The decision must be made by a health professional not involved in the original denial of care,[20] and patients must be informed of their right to appeal.[21]

However, unlike H.R. 2563, the Medicaid rules at stake contain no provision for an appeal to experts external to the managed care plan.[22]

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[13]42 CFR 438.206(d)(2)

[14]42 CFR 438.208(f)(3)

[15]Remarks by the President to the American College of Cardiology Annual Convention. March 21, 2001. (http://www.whitehouse.gov/news/releases/2001/03/20010321-2.html)

[16]H.R. 2563, Section 103(b)(3)

[17]H.R. 2563, Section 103(c)(2)

[18]H.R. 2563, Section 103(d)(3)

[19]42 CFR 438.408(c)

[20]42 CFR 438.406(7)

[21]42 CFR 438.408(f)

[22]Medicaid patients have a separate right to a fair hearing.

4. Women's Health

In March, President Bush declared that "women should be able to visit their gynecologist...without going through a gatekeeper."[23] H.R. 2563 gives women the right to see a "participating health care professional who specializes in obstetrics and gynecology" without requiring authorization or referral from a primary care physician, the plan or any other provider.[24]

The Medicaid rules also offer direct access to obstetrician-gynecologists by including them in the definition of primary care provider.[25]

5. Truth in Marketing

To prevent managed care companies from deceiving patients, H.R. 2563 requires plans to provide information each year on benefits,[26] cost sharing,[27] participating providers,[28] preauthorization requirements,[29] specialty care,[30] prescription drug coverage,[31] emergency services,[32] appeals,[33] translation services,[34] and accreditation.[35] Plan members can also request

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[23]Remarks by the President to the American College of Cardiology Annual Convention. March 21, 2001. (http://www.whitehouse.gov/news/releases/2001/03/20010321-2.html)

[24]H.R. 2563, Section 115(a)(1)

[25]42 CFR 438.2 and 42 CFR 438.206(d)(2)

[26]H.R. 2563, Section 121(b)(1)

[27]H.R. 2563, Section 121(b)(2)

[28]H.R. 2563, Section 121(b)(5)

[29]H.R. 2563, Section 121(b)(7)

[30]H.R. 2563, Section 121(b)(9)

[31]H.R. 2563, Section 121(b)(11)

[32]H.R. 2563, Section 121(b)(12)

[33]H.R. 2563, Section 121(b)(13)

[34]H.R. 2563, Section 121(b)(16)

[35]H.R. 2563, Section 121(b)(17)

specifics on individual physicians[36] and summaries of methods of compensation.[37]

The pending Medicaid rules also require annual disclosure of benefits,[38] cost sharing,[39] participating providers,[40] preauthorization requirements,[41] specialty care,[42] prescription drug coverage,[43] emergency services,[44] and appeals.[45] Patients can request information on translation services,[46] accreditation[47] specifics on individual physicians,[48] and summaries of methods of compensation.[49]

6. Other Provisions

Other provisions in the Medicaid rules are strikingly similar to those in H.R. 2563. For example, both establish protections for patients when coverage is terminated,[50] and both protect physicians' rights to advocate for their patients.[51]

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[36]H.R. 2563, Section 121(c)(1)

[37]H.R. 2563, Section 121(c)(2)

[38]42 CFR 438.10(e)(2)(i)

[39]42 CFR 438.10(e)(2)(ix)

[40]42 CFR 438.10(e)(2)(iv)

[41]H.R. 2563, Section 121(b)(7)

[42]42 CFR 438.10(e)(2)(viii)

[43]42 CFR 438.10(e)(2)(i)

[44]42 CFR 438.10(e)(2)(xiv)

[45]42 CFR 438.10(e)(2)(x)-(xi)

[46]42 CFR 438.10(f)(3)

[47]42 CFR 438.10(f)(1)

[48]42 CFR 438.10(f)(2)

[49]42 CFR 438.10(f)(5)

[50]Compare 42 CFR 436.62 and H.R. 2563, Section 117

[51]Compare 42 CFR 438.102 and H.R. 2563, Section 135

H.R. 2563 also provides additional protections that are not part of the Medicaid rules, including coverage for clinical trials[52] and the right of families to bring their children to a pediatrician.[53]

The remaining provisions in the Medicaid rules cover such basic areas as flexibility for rural areas with few health providers,[54] safeguards for children and adults with special health care needs,[55] provider discrimination,[56] conflict of interest safeguards,[57] solvency standards,[58] the use of practice guidelines,[59] and sanctions for noncompliance.[60] These additional provisions are commonsense rules to protect patients and prevent managed care abuses of millions of vulnerable children, disabled and elderly in the United States.

[52]H.R. 2563, Section 119

[53]H.R. 2563, Section 116

[54]42 CFR 438.52

[55]42 CFR 438.208

[56]42 CFR 438.12

[57]42 CFR 438.58

[58]42 CFR 438.116

[59]42 CFR 438.236

[60]42 CFR 438.700